**June 5, 2001**

Patient has been attending new regim
Coop. He is also attending and participating
South. Patient indicates he likes Park Center
with others. Mother very pleased with son's p
is beginning to express self. Affect since meds
improved.

**July 3, 2001**

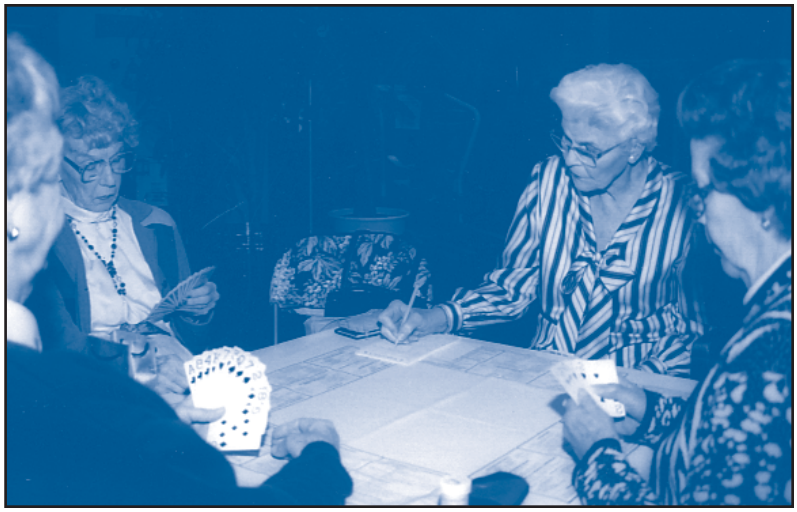
Patient comes to court smiling - a firs
individual therapy at Coop. At Park Cen
kitchen assisting with the preparation
attendees and clean up afte
of computers. Patient also pa
2-3 times per week. However,
participate. He is encouraged to
benefit from sessions.

**August 14, 2001**

Patient still smiling. He continues
At Park Center South, Patient has begu
tasks around Center, in addition to his no
continues to work on computer data entry.
32 words per minute with 97% accuracy. He
therapy sessions, but still does not actively partic
He is again encouraged to express self. Patient is m
He will continue to attend therapy at Park Center
coordinate services with Rutherford County. Next cou
25th.

**Progress Note**

Coop reports that Patient continues to participate in
at Park Center South. His lack of expression in-group sessions
relates to a thick accent or lisp, which has been a source of rid
the past. However, he is showing some signs of involvement and
is addressing self-esteem issues. He relates he is feeling good about
He has developed some friendships at Center and has even gone on
several dates. He loves Park Center and what it is doing for him.



# Respect Your Elders...They'll Probably Be Around a Lot Longer Than You Think

The older population of the United States is growing. And, it is expected to become more diverse this century.

Today, Americans live longer than ever before. People who survive to age 65 can expect to live, on average, nearly 18 more years. Where in 1997, 13 percent of the U.S. population was 65 and older, this number is expected to increase significantly over the next few years.

The health of this group will also vary. Chronic diseases such as heart disease, cancer, stroke and chronic obstructive pulmonary disease are the leading causes of death.

As they get older, millions of Americans will also have to cope with physical limitations, cognitive changes and various losses such as seeing more of their loved ones die.

Their mental capacity is also a factor. Almost 20 percent experience specific mental disorders that are not a part of normal aging.

Many geriatric mental disorders go unnoticed and untreated because older individuals do not seek treatment. And, many family members believe these mental changes are a part of aging. Common mental illnesses include depression and cognitive disorders.

The health of older Americans affects everyone, either directly or indirectly. For the elderly, quality of life is directly influenced by their health, whether mental or physical.

People disabled by chronic conditions or mental illnesses have difficulty living independently. Young and middle-age people who care for aging parents, grandparents, relatives or friends know first hand the challenges of declining health in old age and the cost of services. The financing of health care for the elderly is quite significant.

Prevention is the key in helping the elderly live productive lives. Interventions that reduce the risk of developing, or experiencing the consequences of chronic health problems and mental illness is important. Older individuals should be encouraged to have regular physical as well as mood and memory checkups.

A long and healthy life is a universal goal. In the 20th century, progress was made toward increasing the years and quality of life for most Americans.

In the United States today, most people can look forward to a significant number of years spent in old age.

Whether these will be healthy years, with high levels of physical and mental functioning, the ability to live independently and have access to all types of health care is a concern to all.

Top Left: Emma McAdoo and Ruby Morrison relax after dinner at the Knowles Senior Activity Center.

Top Right: (Left to right) Betty Holmes, Helen Brooks, Olita Kline and Emmy Frost play a friendly game of cards.

Bottom: Dorothy Conner creates a turkey during one of the many arts and crafts sessions held at the Knowles Senior Activity Center.

# Taking the Journey of Hope...

Why me?" It's a question we've all asked as we struggled to accept the fact that someone near and dear to us has a mental illness. We've fought against the realization that our hopes, our plans and our dreams have been replaced by chaos and uncertainty. Yet, for those of us who have experienced the Journey of Hope, we view the question from a different angle. The question of "Why do bad things happen to good people?" is replaced with a new message:

**"What happens when good people happen to bad things?"**

When good people happen to bad things, lives change. Chaos becomes less stressful. Our expectations become more realistic. Old hopes are replaced by new hopes. Nightmares once again become dreams. We learn that we aren't supermen and no one expects us to be supermen. Because others have shared with us, we know that we are not alone.

NAMI Tennessee conducts about 20 Journey of Hope classes per year across the state, taught by family members for family members. One of the greatest rewards of being a Journey of Hope volunteer is hearing participants share the improvements they experience in their quality of life. But because the Journey of Hope is for family members of persons with mental illness, we rarely hear from those we are ultimately striving to benefit - the one who is suffering a mental illness.

The following letter is a welcome reminder of how important those benefits are.

"Dear Journey of Hope Volunteer,

Thank you for teaching Journey of Hope and making a difference in my life. When I had my first psychotic break, many emotions tumbled through my confused brain. I was diagnosed as bipolar. I was very manic. I was self-centered. I could not see that my actions were confusing and even hurting family members. The psychiatrists would talk to me, but shut out my husband. I ignored his problems and expected him to understand the situation and me.

This created a brick wall of misunderstanding. We, normally, had a close relationship. Now, it was being replaced with fighting and distance. I felt anger, loneliness and fear. My mania was replaced with depression that fed on these feelings. My husband did not and could not understand my constant tears. He wondered why I could not just get out of bed and "shake" this off.

I wished for understanding. I felt so alone. I took my meds, but was constantly in and out of hospitals. As hard as he tried, my husband could not understand my bizarre behaviors. Some nights I would stay up all night. One night I had decided to clean the fireplace. I woke my husband to ask him how to do it. He sarcastically told me to use the vacuum. I was not thinking rationally, so that is what I did. I sucked up all that soot and watched it pour into my living room through the vacuum. My husband stalked into the living room when the noise woke him up. Thank goodness he stopped me, but not in time to save that vacuum.

My husband found Journey of Hope and took the class. It saved our marriage. He now understands my illness and can help me watch for early symptoms of mania or depression, which means I get help sooner. We talk openly about my brain disorder, and I do not feel alone anymore. I make sure that my doctors know that he is welcome, and that he is to be informed. My husband is my best friend again. Thank you *Journey of Hope*."

*The Journey of Hope program is an eight-week course for family members and caregivers of persons with mental illness. It is taught by family members for family members. The course provides the opportunity to share feelings and experiences to learn from.*

*The above article appeared in the NAMI-TN News, July-August 2001 edition.*

*For further information on a Journey of Hope program near you, contact Roger Stewart, education coordinator, at (615) 386-3245 or 1(800)467-3589 outside of Nashville.*

# Together We Achieve

These days the term "cultural competence" is often heard but frequently confused with the issue of cultural sensitivity or awareness. Cultural sensitivity is being aware of the needs and feeling of various cultures. Cultural awareness is knowing the similarities and differences among cultures.

Cultural competence, on the other hand, is the ability of an agency or a person to respond respectively and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the worth of the individual and protects and preserves dignity.

According to Melanie Hampton, assistant commissioner for the Department of Mental Health and Developmental Disabilities, cultural competence refers to the ability of organizations and systems to function and perform effectively in cross-cultural situations.

Hampton went on to say that the State of Tennessee is committed to working toward the provision of culturally competent services in all systems that impact adult and child mental health.

Lygia Williams, facilitator for the statewide cultural competence committee, the Triple C, said mental health agencies and providers face a growing challenge to accommodate an increasingly diverse constituency for mental health services statewide.

"The provision of culturally and linguistically appropriate and accessible mental health services regardless of race, gender, age, disability, sexual orientation, national origin, language, religion or socioeconomic status challenges mental health providers to develop, expand and evaluate effective culturally competent services," Williams said.

Williams added that as our population changes so does the mental health consumer base.

"Mental health systems and staff may be unprepared for differences in cultural perspectives, language, traditions and perceptions about mental health treatment," Williams said. "Currently more than 1 in 4 Americans are non-white and/or Latino, but by the year 2050 the U.S. Census Bureau projects that nearly 1 in 2 Americans will be so. Tennessee is preparing for new and changing cultural perspectives, emerging cultural groups and the growing realization that cultural identity contributes in essential ways to mental health well being. Culturally appropriate mental health services are a priority for Tennessee."

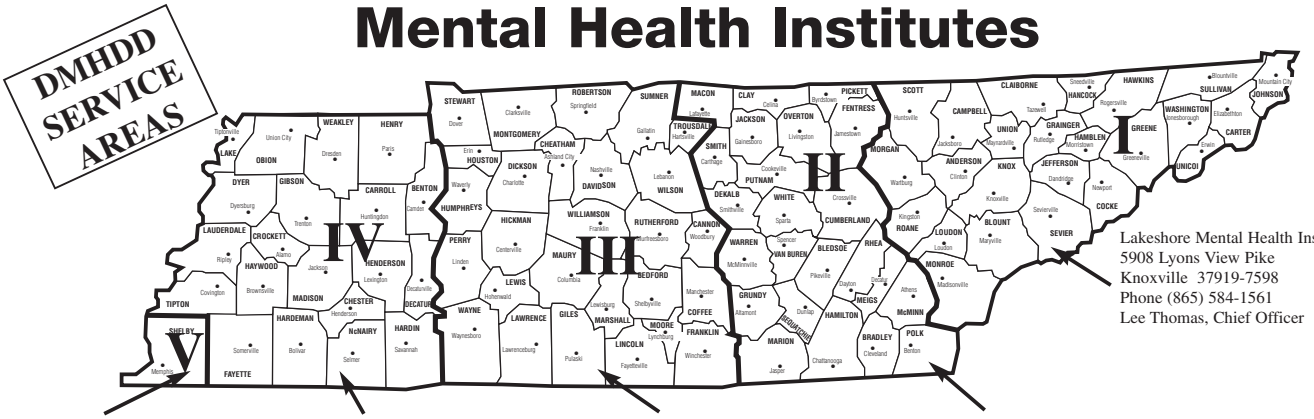
The Triple C, the cultural competence committee for the State Mental Health Planning and Policy Council, has identified a mission and goals for the statewide initiative to promote culturally competent mental health services. Committee members represent the rich diversity of peoples in Tennessee. It is recognized that members of ethnic, racial and culturally diverse groups are often under served or inappropriately served. The committee is dedicated to providing direction for enhancing culturally competent services.

Anita Bertrand, chair for the Triple C, said that through evaluation positive changes could happen.

"Culturally competent and appropriate services can reduce inappropriate diagnosis, increase the utilization of mental health services by population groups that traditionally underutilized services and eliminate the perception of negative encounters experienced by various groups," Bertrand said. "These are groups who have sought treatment from systems that often do not provide culturally sensitive, culturally competent or linguistically appropriate services."

As of today, providers in Tennessee have already begun the process of assessing and developing culturally competent

# Mental Health Institutes




Lakeshore Mental Health Institute
5908 Lyons View Pike
Knoxville 37919-7598
Phone (865) 584-1561
Lee Thomas, Chief Officer

Memphis Mental Health Institute
865 Poplar Avenue, P. O. Box 40966
Memphis, 38174-0966
Phone (901) 524-1200
Michael Coppol, Chief Officer

Western Mental Health Institute
Highway 64-West
Western Institute, TN 38074-9999
Phone (731) 228-2000
Rodger Pursley, Acting Chief Officer

Middle Tennessee Mental Health Institute
221 Stewarts Ferry Pike
Nashville 37243-0980
Phone - (615) 902-7400
Joseph Carobene, Chief Officer

Moccasin Bend Mental Health Institute
Moccasin Bend Road
Chattanooga 37405
Phone (423) 265-2271
William Ventress, Chief Officer

June 2002

# We're Here If You Need Us

Sometimes the community cannot help an individual right away. Or maybe, someone's mental illness is so severe that round-the-clock care is in order. When times like these occur, Tennessee's mental health institutes step in to help.

The top priority for the DMHDD's regional mental health institutes (RHMIs) is to provide in-patient psychiatric services to people with serious mental illness.

The institutes, of which there are five, promote the wellness of individuals under their care to successfully return them to their home and community.

The DMHDD monitors the RMHIs for continued quality, based on the standards and requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Medicaid/Medicare and the U. S. Department of Justice. All RMHIs have been fully accredited by the JCAHO since 1978.